Beyond Conversation in Sensorimotor Psychotherapy: Embedded Relational Mindfulness [1] [2]

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Trauma, particularly early attachment trauma, strongly influences unconscious processes that underlie explicit content in the therapy hour. Trauma-related implicit processes – visibly reflected in non-verbal behaviors of gesture, posture, prosody, facial expressions, eye gaze, and affect – persist in spite of attempts to regulate them with top-down executive control. Patients often feel at the mercy of an overwhelming cascade of dysregulated emotions, upsetting physical sensations, intrusive images, pain, smells, constriction, and numbing. These in turn influence cognitive distortions such as "I am damaged," "I am a bad person," or "I cannot protect myself."

These trauma-related unconscious processes speak to the dominance of what Schore (2009) calls the non-verbal, affective and bodily-based "implicit self" over the verbal, linguistic "explicit self" A therapist's exclusive reliance on the "talking cure" to resolve symptoms of trauma and address implicit processing dynamics can limit clinical efficacy, because forming a coherent verbal narrative of past trauma is typically problematic. Traumatic memories are often not explicitly encoded. Instead, the past is "remembered as a series of *unconscious expectations*" (Cortina and Liotti, 2007, p. 205, italics added), which are all the more potent precisely because memories of the events that shaped them are not available for reflection and revision. Memories may be dissociated – split off from conscious awareness – and many survivors "remember" only isolated affective, sensory or motor aspects of traumatic experience. During trauma, functioning of the prefrontal cortex or "executive brain," responsible for clear thinking and decision-making, and of the hippocampus, involved in the consolidation of emotional and verbal

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memory, is selectively impaired and enhanced in ways that increase emotional processes and their encoding while decreasing conceptual processes and their encoding (Arnsten 2009; Schwabe, Joels, Roozendaal, Wolf, & Oitzl 2012). Attempting to describe the processes that precipitate implicit "remembering" only leads to failure and frustration, or, worse, to reliving.

The primary raw ingredients of therapeutic change lie not in what is explicitly spoken, but the constantly changing experiential context that remains generally unsymbolized in ordinary verbal exchange (Bromberg, 2006). A paradigm shift is indicated that privileges mindful awareness of the moment-by-moment *experience* of implicit patterns over formulating a cohesive narrative, engaging in conversation, or "talking about" (Kurtz, 1990; Ogden & Minton, 2000; Ogden, Minton & Pain, 2006). This chapter offers a practical overview of a clinical map for using mindfulness embedded within what transpires between therapist and patient, and delineates interventions from Sensorimotor Psychotherapy (Ogden, Minton & Pain 2006) that directly address the in-the-moment experience of implicit processes.

What is "Mindfulness"

Definitions of mindfulness vary. Williams and colleagues describe it as "the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to things as they are," a perspective that takes into account internal experience as well as "those aspects of life that we most take for granted or ignore" (Williams, Teasdale, Segal and Kabat-Zin, 2007, p. 47). Included in most descriptions is an attitude of openness and receptivity to whatever arises, as a "quality of attention which notices without choosing, without preference" (Goldstein & Kornfield 1987, p. 19). Many mindfulness practices encourage such unrestricted receptivity, while others described as "concentration practices" promote focusing attention upon particular elements of either internal experience (such as the breath, body sensation, or mantra) or the external environment (such as a candle flame). Several psychotherapeutic methods have been developed that teach mindfulness through structured exercises, practices, and sets of skills. In Linehan's (1993) model, for example, patients are taught mindfulness

"what" skills of observing, describing, and participating, as well as "how" skills of focusing on one thing at a time and being effective.

Kurtz (2004), building on Buddhist perspectives, describes the essence of mindfulness:

> "to be fully present to our [internal] experience, whatever it is: our thoughts, images, memories, breath, body sensations, the sounds and smells and tastes, moods and feelings and the quality of our whole experience as well as of the various parts. Mindfulness is not our notions about our experience, but even noticing the notions" (2004, p.39).

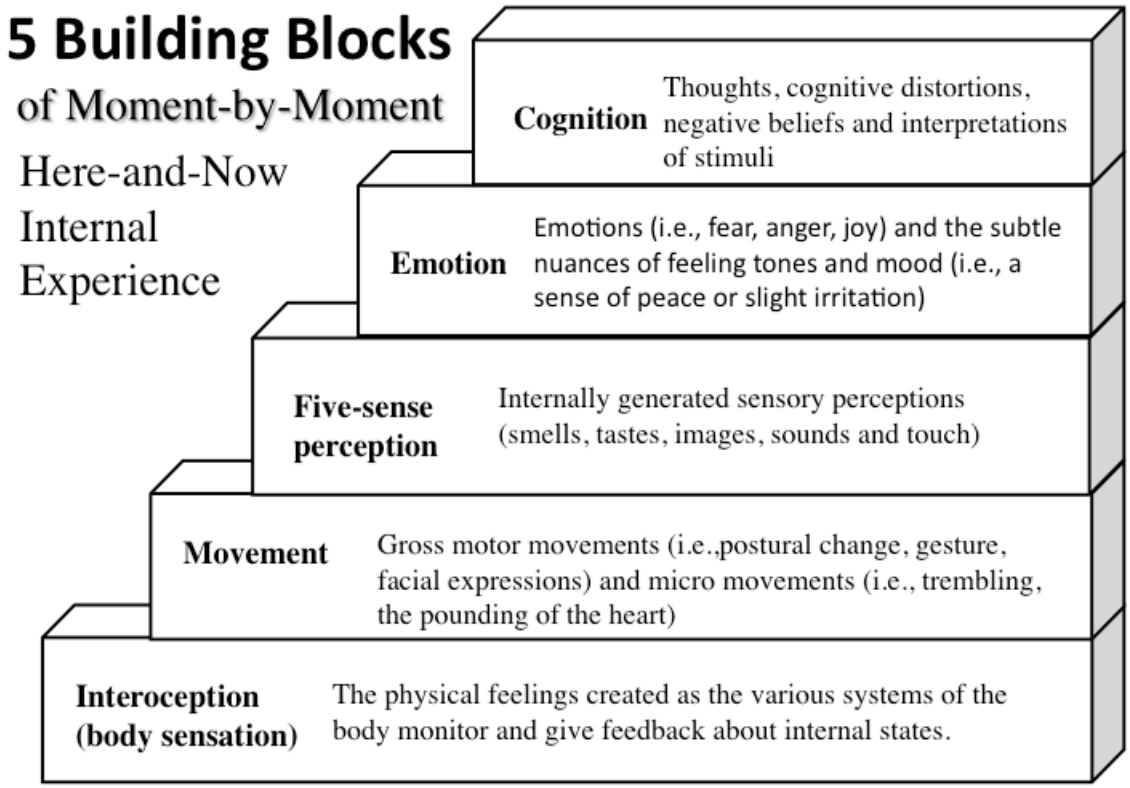
Sensorimotor Psychotherapy, influenced by Kurtz, employs a specific clinical "map" and a set of therapeutic skills for the purpose of inquiring into the direct moment-by-moment internal experience of the effects of trauma . Mindfulness is not taught through structured exercises or practices, but is integrated with and embedded within what transpires moment-to-moment between therapist and patient.

A Map for the Use of Mindfulness in Clinical Practice

In the Sensorimotor Psychotherapy, the clinician maintains a dual focus: One is following the patient's narrative or "story." The other, more important focus is tracking the five "building blocks" of present-moment internal experience – emotions, thoughts, five sense perception, movements and body sensations – that emerge spontaneously in the therapy hour and become the focal points of mindful exploration and transformation (cf. Ogden, Minton & Pain 2006). These building blocks are elaborated in Figure 1:[3]

[3] Figure 1 design: Anne Westcott

Figure 1



Reflecting implicit processes, these five elements comprise the present-moment internal experience of every waking moment – at least potential internal experience, as they often occur outside of awareness. They change in response to themselves, with internal thoughts affecting emotions, which in turn associatively evoke internal perceptions, and so on. They also change in response to external stimuli.. The building blocks are dramatically impacted by both internal and external traumatic reminders that bring the past abruptly into the experiential present. When triggered by such reminders, patients report disturbing body sensations, movements, intrusive images, smells or sounds, fear, shame, panic or rage, and thoughts – all of which can spin out of control – even while realizing cognitively that these reactions do not match current reality. As one client put it, "I know I'm safe, but my body is running amok. I shake, I panic, I see my father's face, and I feel like I will die."

Rather than conversation, the focus of therapy becomes *the spontaneous fluctuations of these five elements*. The therapist is on the lookout for specific building blocks that point to implicit processes that reflect unresolved trauma, as well as those that reflect self-regulatory resources, positive affect, competency, and mastery. Together, therapist and patient interrupt the automaticity of these building blocks by becoming mindful of them. In this way, the patient can identify and observe, rather than identify with, the effects of the past trauma, and discover more adaptive actions (cf Ogden et al 2006).

Mindfulness is "motivated by curiosity" (Kurtz, 1990, p. 111), and thus "'allow[s]' difficult thoughts and feelings [and images, body sensations and movements] simply to be there…. to adopt toward them a more "welcome" than a 'need to solve' stance" (Segal et al., 2002, p. 55). The therapist, by example and encouragement, helps the patient cultivate an attitude of curiosity, neutrality, and receptivity toward internal experience. However, unrestricted mindfulness toward any and all of the five building blocks can be disturbing and overwhelming to people with PTSD, and thus is often met with dismay, judgment, self-criticism and further dysregulation. To help prevent this, a Sensorimotor Psychotherapy approach employs mindfulness in very specific way, termed "directed mindfulness," which entails carefully and firmly directing the patient's mindful attention toward one or more of the five building blocks considered important to therapeutic goals (Ogden 2007; 2009). For example, if an internal image of past trauma or an external traumatic reminder such as the sound of a siren causes hyperarousal, a therapist might direct a patient to become mindful of the sensation in her legs to promote grounding, rather than to the internally generated image, because grounding supports the goal of stabilization.

Safety, Danger and Mindfulness in the Therapeutic Relationship

Critically, mindfulness in Sensorimotor Psychotherapy is not a solitary activity, but is firmly embedded in what occurs within the therapeutic dyad. It is imperative that mindfulness is employed in a way that increases patients' experience of relational safety and fosters their ability to connect to and engage with the therapist. However,

maintaining the moment-by-moment therapeutic alliance is precarious, because both external reminders of the trauma and recurring internal images, thoughts, emotions, and sensations are implicitly triggering, which elicits primitive defenses and dysregulated arousal. If danger is (implicitly or explicitly) detected, this produces either mobilization behaviors (fight/flight) accompanied by hyperarousal and tense muscles that prepare for defensive fight or flight behaviors, or immobilization behaviors accompanied by hypoarousal, shut down or "feigned death," and a loss of muscular tension. Social behaviors can continue only if these defenses can be inhibited sufficiently so that patients can experience some degree of relational safety.

Porges (2004; 2011) introduced the term "neuroception," to be distinguished from "perception," in order to emphasize the brain's automatic detection of environmental features that are safe, dangerous, and life threatening. This detection is usually implicit and strongly affects physiological state to produce social, active defensive, or shut down behaviors. When safety is neurocepted, levels of autonomic arousal fluctuate within a "window of tolerance" (Siegel 1999) in which behaviors typical of engagement with others can take place. In therapy, patients must automatically detect or neurocept some degree of safety in order to remain engaged with the therapist, otherwise therapy cannot take place. However, as stated, traumatized patients are often unable, based on prior conditioning, to detect accurately whether the environment is safe or another person is trustworthy. This difficulty is exacerbated in therapy when traumatic material is deliberately stimulated, which it must be in order to resolve the past. The therapist intends to bring patients' experience of the past into the therapy hour but this can cause the patient to implicitly neurocept danger, which activates the brain's fear circuitry, stimulates the sympathetic nervous system, and mobilizes fight/flight/shut down defenses.

It is important to note that the patient's neuroception of the environment as safe or dangerous occurs implicitly, triggering defensive or social behaviors usually without any conscious awareness. As Porges (2004) states, "Even though we may not be aware of danger on a cognitive level, on a neurophysiological level, our body has already started a sequence of neural processes that would facilitate adaptive defense behaviors such as

fight, flight, or [shut down]." Patients and therapists alike are often baffled by the patient's unexpected change from social to defensive behaviors. The stimulus that provoked the change is typically not conscious for either party.

Therapists must pay exquisite attention to the non-verbal signals that suggest state changes from regulated arousal (the patient's neuroception of safety) to dysregulated arousal and defensive responses (the patient's neuroception of danger and life threat) and take steps to help patients inhibit defensive systems enough so that their social engagement can continue or return. Taking place within an attuned dyad, mindfulness must be used to activate not only patients' experience of trauma and dysregulated arousal but also to *ensure that their social engagement is intact*. In other words, the patient must detect safety and danger simultaneously. Detecting only safety would preclude addressing past trauma, and detecting only danger would lead to reliving the trauma. The simultaneous evocation of both implicit trauma-related dysregulating processes and safe social engagement can result in a depth of intersubjectivity and connectedness that exceeds that which ensues from conversation alone. However, for this to occur, a specific set of relational mindfulness interventions must be privileged over ordinary conversation, discussion or "talking about" (Kurtz 1990; Ogden et al 2006) and over solitary mindfulness exercises or practices.

Directed Mindfulness Therapeutic Skills and Embedded Relational Mindfulness

In Sensorimotor Psychotherapy, therapists closely and unobtrusively "track" the patient's unfolding experience of body sensations, movements, five-sense perceptions, emotions and thoughts in response to particular stimuli, such as a description of past trauma or current difficulty. The therapist is on the lookout for changes in sensation (like flushing or blanching), shifts in movement (posture or gesture), internally generated perceptions (reports of images, smells, tastes, sounds), emerging emotions (moist eyes, facial expression or prosody), or beliefs and cognitive distortions that emerge from the patient's narrative. In addition, connections among the building blocks are noted, for example, the thought "It's my fault," expressed as the patient reports the image of her mother's unwelcoming face when she turned to her for comfort, emerges as her posture slumps, her face blanches, and her expression reflects sadness.

These tracked elements of present moment experience typically remain unnoticed by the patient until the therapist brings attention to them, through a "contact statement" that describes what has been noticed, such as, "As you see your mother's face, your posture slumps", or "You seem to feel hopeless right now." Therapists of all persuasions are skillful at reflective statements that convey their understanding of the narrative ("That must have been so painful for you." Or "You were devastated by that experience"). Although it is important for the patient to know that the therapist is following the narrative details, it is essential to contact present moment experience in order to facilitate mindfulness. If therapists only verbalize their understanding of the narrative, patients will assume that the narrative, rather than present moment experience, is of the greatest import, influencing them to continue the conversation. Contacting present experience repeatedly shifts the patient's attention "to the various things going on outside of the flow of conversation, to experiences" (Kurtz, 2004, p. 40) that can then be further explored through mindful awareness.

Contact statements should convey empathic understanding of the patient's present experience (Kurtz 1990' Ogden et al 2006). Thus is it not only the words therapists say, but also their non-verbal body language, affect, and prosody that modulate patients' fear circuitry and stimulates the systems underlying experiences of safety and social engagement. These contact statements emerge from the clinician's own implicit processing as "the therapist resonates with the patient's internal state of arousal dysregulation, modulates it, communicates it back prosodically in a more regulated form, and then verbally labels his/her states experiences" (Schore, 2003b, p. 30). Such resonance followed by "labeling" or naming allows patients to contact here-and-now experience and paves the way for mindful exploration of that experience.

The therapist and patient collaborate to determine what to explore through mindful attention. This decision constitutes a commitment to a certain direction for the session in general – whether to start by exploring the present moment effects of trauma, such as an intrusive image, cognitive distortion, or physical constriction, or instead something that points to resources, like relaxation, a sense of joy, a "positive" cognition, or a peaceful image. The therapist may have tracked and contacted shifts in experience as the patient talks about a memory ("It seems your shoulders and arms start to tighten

when you talk about this memory") and may suggest, "Let's find out more about the tightening that emerges when you think about the memory." If the patient agrees, the tension becomes the stimulus for mindful study.

Only after tracking, contacting and deciding to explore an element of present experience does the therapist ask directed mindfulness questions that require awareness of present moment experience. If the tension in the shoulders and arms is chosen, the induction to mindfulness might be, "As you sense that tension, what can you learn about it – how is it pulling? Is it the same in both shoulders and arms?" If the thought "I know I'm OK" is chosen, the induction to mindfulness might be a questions such as, "Stay with that thought, 'I know I'm OK.' Repeat the words in your mind, and notice what happens. What images, body sensation or emotions come up by themselves?" Note that mindfulness is directed so that patients become aware of the spontaneous emergence of the building blocks in response to a particular stimulus (the tension or the thought).

Case Illustration

Sensorimotor Psychotherapy is conducted within a phase-oriented treatment approach, identified by Janet (1898) as comprising three phases: symptom reduction and stabilization; treatment of traumatic memory; and personality integration and rehabilitation. Excerpts from Suzi's treatment will illustrate how the clinical map and therapeutic skills for mindfulness are utilized at each phase of treatment. Suzi, sexually abused as a child and currently 27 years old, began treatment reporting that she lived in fear, with frequent escalation in heart rate and a constant sense of impending danger.

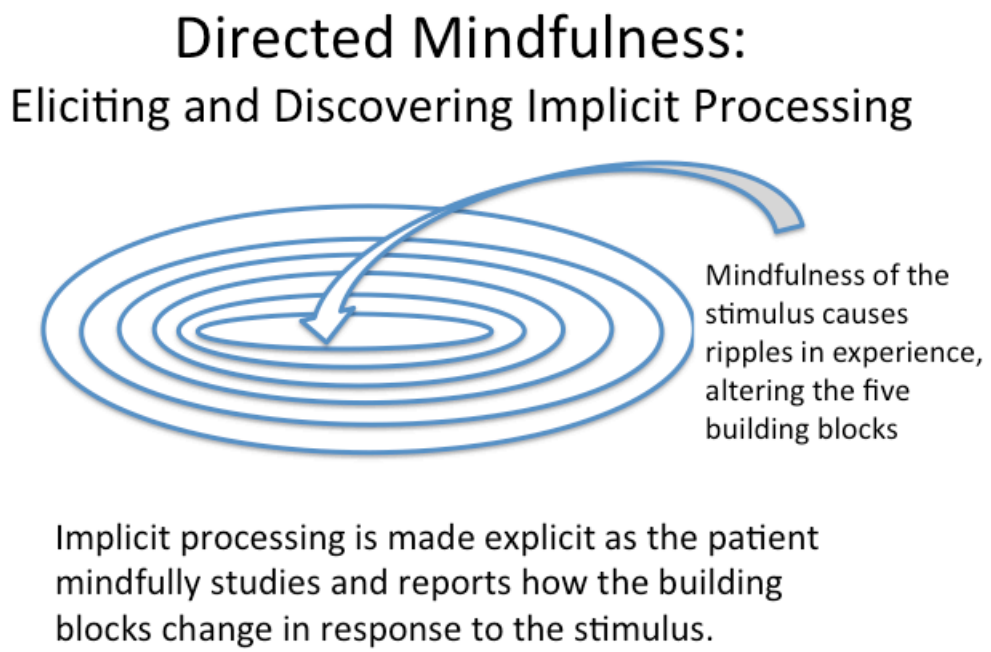
Early in treatment, as Suzi discussed her history I tracked her shallow breathing, the fear in her widened eyes, the vivid image of her father's contorted face, and the thread of a cognitive distortion heard in the words she chose and her prosody ("I never should have been born," said in an self-deprecating, hopeless manner). Naming specific elements of Suzi's present experience ("You don't seem to be breathing fully") was followed by Suzi's report that she felt numb, especially in her legs. I collaborated with her in deciding to focus on the numb sensation, in the hope that she could "ground" herself and bring her arousal into a window of tolerance. Thus numbness became the stimulus for directed mindful exploration: "What happens when you sense that numb feeling? Can you

describe that sensation of numbness? Do you feel it equally in both legs?" Note the difference between these questions and non-directive general mindfulness question, such as "What do you notice right now?" In Sensorimotor Psychotherapy, mindfulness includes the patient's labeling of internal experience using language, which engages the prefrontal cortex (Siegel, 2007).

As Suzi described the numbness, she noticed an achy pressure – a feeling that changed to "energized" as she experimented, at my suggestion, with pressing her feet into the floor, an action intended to facilitate grounding (Ogden et al 2006). This action became the second stimulus for mindful study, as I asked Suzi to notice what occurred as she did it. She took a deep breath, then said she felt less fearful and that she could "be here." Her arousal returned to within a window of tolerance, in accord with the "stabilization" goal of Phase One of trauma treatment. Outside of therapy, to help her regulate her arousal, Suzi practiced pushing her feet into the floor over and over.

In Phase Two of treatment, Suzi discovered her forgotten, dormant defensive impulse to protect herself. As she remembered how she became frozen and did not resist her father's sexual advances, the building block I contacted was the tension of her arms, saying "It looks like your arms are tensing up as you talk of your father." I selected the tension because I hypothesized that the tension was a preparatory movement of pushing away – an instinctual defensive response that Suzi had unconsciously refrained from executing at the time of the trauma when active resistance would have only made her father angry. Suzi was not aware of the tension until I named it. Together, we decided that it would be the stimulus to study in mindfulness. To illustrate the use of mindfulness of a stimulus, Kurtz (2004) used the metaphor of tossing a pebble in a pond and watching the ripples. The quieter the pond is, the more the ripples are visible. I asked Suzi to take her time to gently become aware of the tension and asked, "What happens when you sense this tension? Is the tension in both arms equally? How is it pulling?" This was a turning point in the session, because the focus shifted from conversation about her abuse to mindful study of a specific here-and-now manifestation of her body's response to the abuse while talking about it – the tension. This "telling" elicits implicit processing, reflected in present moment alterations in the internal experience of the five building blocks, as illustrated in Figure 2.

Figure 2



As Suzi became mindful, she first reported feeling "frozen," but her fingers lifted slightly, which I tracked and named. Suzi was surprised and curious that her fingers lifted, and I asked, "As you sense the lifting of your fingers, what does your body want to do," directing Suzi to take her time to sense the impulse from her body itself, not her "idea" of the impulse. She reported, "My arms want to push away but I feel scared to do it. I keep seeing my father's face." I firmly directed her mindful attention exclusively to her body: "Let's just sense your body. Put the fear and the image of your father aside for now. Let's just follow what your body wants to do." This exclusive focus on physical sensation and impulses enabled Suzi to execute an "act of triumph" (Janet, 1925) by pushing against a pillow that I held. The execution of this empowering defensive response elicited a feeling of satisfaction and pleasure, and Suzi reported, "I feel strong! This is a new feeling and it feels good!" Through directing mindful attention to her body rather than to the image of her father's face, the instinctive impulses to push away – which Suzi could not act upon at the time of the abuse – developed into an action that led

to the discovery of her lost ability to defend herself. The connection between the two of us deepened as this long dormant, empowering action emerged spontaneously, was executed and deeply experienced by her, and was accepted by me.

Over many sessions, after the stabilizing skills gained in Phase One treatment, and the working through of traumatic memory in Phase Two, Suzi was ready to address Phase Three treatment goals of increasing her capacity for intimacy and challenging her "implicit relational knowing" (Lyons-Ruth 1998). While Suzi desperately longed for a mate, her habits of implicit processing reflected in frozen tension and fear had prevented her from seeking an intimate relationship. These habits became our focus in Phase Three treatment.

Proximity-seeking actions are abandoned or distorted when they are persistently ineffective in producing the desired outcome from attachment figures. These can become the targets of mindful exploration in Phase Three treatment. I asked Suzi if she would be interested in noticing what happened if she reached out with her arm or arms toward me. She agreed, and this movement of reaching, a proximity-seeking action, became the stimulus to explore. As Suzi reached out, the part of her that had inhibited that action came forward, and Suzi reported feeling frightened. Exploring actions that are alternatives to habitual action tendencies can bring forward parts of the patient that are "inhospitable and even adversarial, sequestered from one another as islands of 'truth,' each functioning as an insulated version of reality" (Bromberg, 2010, p. 21). Suzi became more fearful as she reached out, saying "The thought comes up, 'I'm going to get hurt.'" She avoided eye contact and remembered how climbing up on her father's lap would lead to abuse. Eventually, Suzi discovered a new action: Raising one arm, palm outward in front of her body in a protective motion, Suzi reached toward me with the other arm. She reported that with this dual action she felt calm and strong. Her spine straightened, and she was able to maintain eye contact with me. I wondered if these gestures could be translated into words, and Suzi replied, "I can both defend and connect." Remembering the words and the action helped Suzi feel safe enough to begin to venture out into new social situations that she had previously avoided.

Conclusions

Mindfulness develops "the skill of seeing [the] internal world, and … shapes it toward integrative functioning" (Siegel, 2010, p. 223). It focuses attention on interrupting old implicit processing and creating new experiences: "the brain changes physically in response to experience, and new mental skills can be acquired with intentional effort with focused awareness and concentration" (Siegel, 2010, p. 84). In Sensorimotor Psychotherapy, mindfulness – specifically mindfulness embedded in the moment-to-moment interaction between therapist and patient – is privileged over conversation. The therapist repeats directed mindfulness skills throughout the clinical hour, as illustrated in Figure 3.

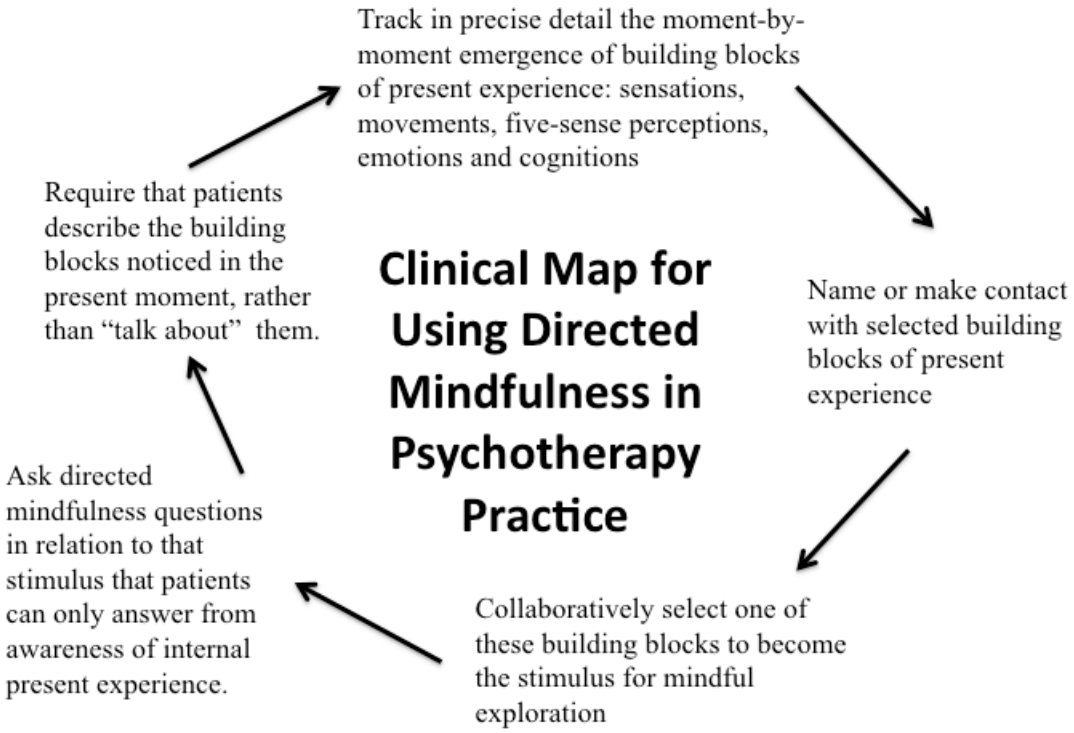


Figure 3

The verbal narrative, while indispensible in clinical practice, cannot provide the same in-the-moment revelations that about the patient's implicit processing that mindfulness can, nor can it facilitate new physical actions within the relationship. Even when the content that implicit processing represents remains unarticulated, or even unremembered, mindful

attention toward the here and now effects of past trauma can bring about therapeutic change. Sensorimotor Psychotherapy (Ogden et al., 2006), with its embedded relational mindfulness and directed mindfulness techniques, provides a map and tools for healing trauma in this way.

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